CUSTOMER AGREEMENT - Wisconsin Prescription Drug Resource Center Version

No prescription(s) will be filled until a signed and dated copy of this document and a completed Patient Profile have been received by Granville Pharmacy. These documents can be sent by fax to: **1-877-919-7347** or mailed to **Granville Pharmacy, Suite 205, 3077 Granville St., Vancouver, BC, Canada V6H 3J9, Customer Service: 1-888-730-3338**

I, as the undersigned, being over the age of 21, hereby:

Disclosure and Representations

Represent and confirm to **OnlineCanadianpharmacy.com, Granville Pharmacy**, its affiliates, related companies, subsidiaries and parent company (hereinafter collectively referred to as **"GVP"**) that:

1. The pharaceutical(s) to be delivered to me were prescribed by a doctor licensed to practice medicine in the country, state, or other jurisdiction in which I reside or where I sought treatment. I will not seek the delivery of medication that represents my first use of such medication.

2. The prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician.

3. I will use any medication obtained for me by **GVP** strictly according to the instructions provided by the physician who prescribed the medication.

4. The pharmaceutical(s) will only be used as directed and only by the person for whom the pharmaceutical(s) were prescribed.

5. I can make my own medical decisions according to the law of the place where I reside.

6. The prescription(s) I am requesting **GVP** to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to **GVP**. I agree to immediately destroy all copies of my prescription(s) once it has been filled.

7. I am not seeking or relying on any medical information from **GVP** and I have consulted a qualified physician licensed where I obtained the prescription within the last year.

8. I will immediately contact the physician who provided my prescription included with this order in the event I suffer any unexpected side effects from any medication obtained for me by **GVP**.

9. I understand that it is my responsibility to have regular physical examinations by my primary US licensed physician that is responsible for my care including all suggested testing to ensure that I have no medical problems which would constitute a contraindication to me taking the medications being prescribed.

10. I acknowledge that **GVP**'s employees and agents have relied on the information and documentation that I am providing (including the Patient Profile) and I represent and confirm that I have fully disclosed all pertinent information and documentation to **GVP**. I agree to notify **GVP** of any changes to my physical or medical condition by providing an updated Patient Profile.

Authorization and Consent

11. I hereby authorize and appoint **GVP**, as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain a prescription in **Canada** that is the equivalent of the prescription that I sent to **GVP**, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to **GVP** employees, agents and service providers including the Canadian physician being retained on my behalf, as required, for the limited purpose of obtaining the Canadian prescription. The authorizations and consents that I am providing to **GVP** commence on the date I have signed this agreement and shall continue until I revoke them. I understand that I can revoke the consents and Authorizations I have granted to **GVP** at any time.

12. I hereby specifically acknowledge that I am aware that **GVP** will be transmitting my personal health information by electronic means (for example fax, secure internet) to its employees, agents, affiliates and service providers including the Canadian physician retained on my behalf. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that **GVP**, as a custodian of my personal health information will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to **GVP**'s transmission of my personal health information by electronic means.

13. If I was directed to **GVP**'s services through an affiliate or intermediary (for example Pharmacy Benefit Manager, Health Management Organization, or other healthcare service provider), I hereby authorize **GVP** to release the following data to such an intermediary:

    a. a numerical identifier indicating that I was a patient referred from that source;

    b. financial information that will permit the processing of any claims on my behalf.

    It is my understanding that all such intermediaries will enter into Confidentiality Agreements where they agree to abide by the privacy policies of **GVP** relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.

14. I authorize and appoint **GVP** as my agent and attorney for the purpose of taking all steps and signing all documents on my behalf necessary to package or re-package the pharmaceutical(s) and to deliver them to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.

15. I authorize and appoint **GVP** as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceutical(s) to me as if I had shipped the prescribed pharmaceutical(s) to my own address.

16. I acknowledge and agree that I initiated a consultation with **GVP** and that **GVP** is not located in the United States. I also acknowledge that the pharmacists working for **GVP** and the physicians contracted by **GVP** on my behalf are located and licensed to practice medicine or pharmacy in **Canada** and that all services that I receive from the Canadian pharmacy and the pharmacist are being received in **Canada**.

17. I further agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and **GVP** shall be deemed to be made in the **Province of British Columbia, Canada and accordingly shall be governed by the laws of the Province of British Columbia and the laws of Canada applicable to such contracts and agreements.**

18. I agree that any dispute that arises between me and **GVP**, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees, agents and contractors shall be governed by the laws of the

Province of British Columbia and the laws of Canada applicable to contracts formed in British Columbia, and I agree that the courts of the Province of British Columbia shall have sole and exclusive jurisdiction over any such dispute.

Purchase and Sale Terms

19. **Granville Pharmacy** will charge my credit card the following amounts:

a. the medication price and shipping (in **US Dollars**) as posted on the Wisconsin Prescription Drug Resource Center web site on the day **GVP** receives my order, or the price and shipping (in **US Dollars**) as posted on the **GVP** web site on the day **GVP** receives my order, whichever is less; and

b. in the event my payment is not authorized, **GVP** has the right to cancel my order and attempt to provide me with notice of such cancellation.

20. The pharmaceutical(s) will be packaged in child protected packaging, unless requested otherwise by me on the Patient Questionnaire.

21. That once purchased and shipped, no pharmaceutical product may be returned or exchanged.

22. **GVP** reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitled to a refund for monies paid for such order.

23. **GVP** does not provide its agency or attorney services as a substitute for healthcare or the advice of the customer's primary care physician.

24. **GVP** will not exchange medication or return any monies paid once an order is filled, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription.

I have read and understood the terms and conditions set out in this Agreement and agree, on behalf of myself, my heirs, successors, administrators and assigns to be bound by these terms and conditions.

Signed this_____ day of _____, 20_____.

_____ _____

Signature Print Name

Creating Your Health Profile

*** It is mandatory that you have had a complete physical examination in the past 12 months.**

Have you had one? ❑ Yes ❑ No

*Denotes Required Information. These fields must be complete for us to process your information. '

Patient Information: (Please Print Clearly)

(primary address)

*First Name: _____ Middle Name:_____ *Last Name:

* Weight (Ibs): _____*Gender: ❑ Male ❑ Female *Date Of Birth: Day _____ Month _____Year_____

*Primary Address: _____

*City/Town_____ *State_____*Zip Code _____*Country _____

Email: _____

*Phone (Home): _____Phone (Work):_____

Fax: _____Phone (Cell): _____

Where Would *you* like this order shipped? ❑ Primary Address ❑ Alternate Address Please provide any other shipping information below.

_____

_____

Physician Information

*First Name: _____*Last Name: _____

*Address: _____

*City/Town_____ *State_____*Zip Code _____ *Country_____

*Phone: _____Fax: _____

Patient Personal Medical History: (*All Fields in this section are required)			
	Never	**Previou**	**Current**
1). Blood disorders	❑	❑	❑
2). Cancer	❑	❑	❑
3). HIV / AIDS	❑	❑	❑
4). Poor wound healing	❑	❑	❑
5). Parkinsons Disease	❑	❑	❑
6). Epliepsy	❑	❑	❑
7). Schizophrenia	❑	❑	❑
8). Diabetes	❑	❑	❑
9). Thyroid disorders	❑	❑	❑
10). Other endocrine disorders	❑	❑	❑
11). Known nutrition deficiency including minerals or electrolytes	❑	❑	❑
12). Heart disease including atherosclerosis, angina, heart failure or history of heart attack	❑	❑	❑
13). Renal or kidney disease	❑	❑	❑
14). Liver disease	❑	❑	❑
15). Anxiety	❑	❑	❑
16). Depression	❑	❑	❑
17). Recent Surgery	❑	❑	❑
18). Glaucoma	❑	❑	❑
19). Hyperlipidemia (high cholesterol)	❑	❑	❑
20). Chemical dependency	❑	❑	❑
21). Asthma	❑	❑	❑
22). Emphysema	❑	❑	❑
23). COPD (Chronic Obstructive Pulmonary Disease)	❑	❑	❑
24). Smoker	❑	❑	❑
25). Rheumatoid arthritis, lupus, or connective tissue diseases	❑	❑	❑
26). High blood pressure	❑	❑	❑
27). Osteoporosis	❑	❑	❑
28). Alzheimers Disease	❑	❑	❑
29). Osteoarthritis	❑	❑	❑

Do you have any other illness not listed above? ❑ Yes ❑ NO
***If answered yes to any of these questions, please explain further.**

Prescription Information:

***How will you get the copy of the original Prescription to the Pharmacy?**	Yes
1). I will fax the Prescription to the Pharmacy and send the original by mail.	❑
2). Physician will fax Prescription to the Pharmacy.	❑
3). I will send the Prescription to the Pharmacy by mail.	❑

Allergy Information: (*All Fields in this section are required):

Please check off any drug allergy that you may have:

	Yes	**No**
1) Penicillins (Amoxicillin , Ledercillin VK, Ampicillian)	❑	❑
2) Sulfonamides (Bactrim, Septra, Cotrim)	❑	❑
3) Opiod Analgesics (Codeine, Morphine, Fentanyl)	❑	❑
4) Sulfur	❑	❑
5) Salicylates - Aspririn	❑	❑
6) Macrolides (Biaxin, Erythromycin, Zithromax)	❑	❑
7) NSAID's - Naprosysn	❑	❑
8) Meperidine and related (Demerol)	❑	❑
9) Iodine	❑	❑
10) Tetracyclines (Tetracycline, Minocycline, Doxycycline)	❑	❑
11) Quinolones (Cipro, Noroxin, Levaquin)	❑	❑
12) Cephalosporins (Keflex, Ceclor, Cefzil, Ceftin)	❑	❑
13) Tetatunus Toxoid (Tetanus)	❑	❑
14) Glucocorticoids (Prednisone, Cortisone, Dexamethasone)	❑	❑
15) Cox-2 Inhibitor (Vioxx, Celebrex, Bextra)	❑	❑
16) A.C.E. Inhibitors (Vasotec, Altace, Zestril, Accupril, Capoten)	❑	❑
17) Nitrofuran derivatives (Macrobid, Macrodantin)	❑	❑
18) Antihistamines (Benadryl, Allegra, Zyrtec, Claritin)	❑	❑
19) HMG-COA Reductase enh - Leschol	❑	❑
20) Penicillamine (Penicillamine, Culprimine)	❑	❑
21) Calcium Channel Blocking Agents (Norvasc, Diltiazem, Verapamil)	❑	❑
22) Aminoglycosides (Gentamycin, Tobramycin)	❑	❑
23) Benzodiazepines (Valium, Ativan, Restoril, Klonopin)	❑	❑
24) Beta Adrenergic Blocking Agents (Inderal, Tenormin, Sectral, Betapace)	❑	❑
25) Hydantoins (Phenytoin, Dilantin)	❑	❑
30) Quinidine/Quinine	❑	❑
31) Acetaminophen (Tylenol)	❑	❑
32) Proton Pump Inhibitors - Benzimidazole (Nexium, Protonix, Prilosec, Prevacid)	❑	❑
33) Niacin preparations (Niacin)	❑	❑
34) Metoclopramide (Metoclopramide, Reglan)	❑	❑
35) Metronizadole(Flagyl, Noritate, Metrogel)	❑	❑
36) Selective Serotonin Reuptake enh - Prozac	❑	❑
37) Histamine H2 Inhibitors (Zantac, Tagamet, Pepcid)	❑	❑

38) Barbiturates (Phenobarb, Secobarbital, Butabarbital)	❑	❑
39) Carbamzepine (Tegretol)	❑	❑

Do you have any drug allergies not listed above? ❑ Yes ❑ No *
If yes, please list below and describe the reactions.

_____

_____

_____

Current Medications:

Please list all medications you are currently taking and the condition for which they have been prescribed for:

Drug Name	Strength	Directions for use	How long you have been taking this drug?	Quantity Requested	Medical condition this drug is used to treat
Example Drug	**12mg**	**1 tablet a day**	**8 months**	**90 pills**	**Thyroid**
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					

NOTE: We will send you a 90 day supply unless otherwise specified. It is generally cheaper to get a 90-day supply; You will get 1 delivery charge instead of 3 and you will receive the benefits of volume discounts on most medications.
To minimize waiting time, please ask your physician to write the prescription for a 3-month supply plus 3 refills. Your initial order for each prescription will be delivered between 14 and 21 days in most cases. All refills should be delivered in approximately 10 days.

Medications You Wish To Order:

Please list all medications you wish to order:

Drug Name	Strength	Directions for use	How long you have been taking this drug?	Quantity Requested	Medical condition this drug is used to treat
Example Drug	**12mg**	**1 tablet a day**	**8 months**	**90 pills**	**Thyroid**
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					

Your Billing Information:

* Name on Credit Card: (Please Print Clearly)

Credit Card Type: Visa ❑ MasterCard ❑

Credit Card Number: _____

Expiration Date: _____ Month _____Year:_____

Fax: 1-877-919-7347